FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0026294

Facility Name: All American Nursing Home

Address: 5448 North Broadway (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 334-2224 **Fax #** (773) 334-0360

HFS ID Number:

Date of Initial License for Current Owners: 5/8/1981

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	96	Intermediate (ICF)	96	35,040	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	36,284			36,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,284			36,284	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.03%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/08/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/08/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/17 Fiscal Year: 12/31/17

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,499	42,757	8,784	379,040		379,040	12,328	391,368			1
2	Food Purchase		195,445		195,445	(8,161)	187,284		187,284			2
3	Housekeeping	273,899	38,601		312,500		312,500		312,500			3
4	Laundry	26,885	9,670		36,555		36,555		36,555			4
5	Heat and Other Utilities			125,490	125,490		125,490	(3,394)	122,096			5
6	Maintenance	260,195	74,090	95,277	429,562		429,562	8,339	437,901			6
7	Other (specify):*							1,538	1,538			7
8	**TOTAL General Services**	888,478	360,563	229,551	1,478,592	(8,161)	1,470,431	18,811	1,489,242			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,649,927	35,075	9,628	1,694,630		1,694,630		1,694,630			10
10a	Therapy	29,432		54,554	83,986		83,986		83,986			10a
11	Activities	75,506	1,821	1,692	79,019		79,019		79,019			11
12	Social Services	134,759		3,476	138,235		138,235		138,235			12
13	CNA Training											13
14	Program Transportation			666	666		666		666			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,889,624	36,896	85,016	2,011,536		2,011,536		2,011,536			16
	C. General Administration											
17	Administrative	125,780		393,100	518,880		518,880	(294,633)	224,247			17
18	Directors Fees											18
19	Professional Services			75,504	75,504	(204)	75,300	3,834	79,134			19
20	Dues, Fees, Subscriptions & Promotions			36,200	36,200		36,200	(11,045)	25,155			20
21	Clerical & General Office Expenses	41,982	47,611	33,097	122,690		122,690	73,010	195,700			21
22	Employee Benefits & Payroll Taxes			507,942	507,942	8,161	516,103		516,103			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,086	1,086		1,086	141	1,227			24
25	Other Admin. Staff Transportation			1,867	1,867		1,867	4,375	6,242			25
26	Insurance-Prop.Liab.Malpractice			172,618	172,618		172,618	2,437	175,055			26
27	Other (specify):*							50,119	50,119			27
28	**TOTAL General Administration**	167,762	47,611	1,221,414	1,436,787	7,958	1,444,745	(171,762)	1,272,983			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,945,864	445,070	1,535,981	4,926,915	(204)	4,926,711	(152,951)	4,773,760			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number All American Nursing Home #0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,415	42,415		42,415	144,627	187,042			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,135	63,135		63,135	(6,894)	56,241			32
33	Real Estate Taxes			203,934	203,934	204	204,138	6,308	210,446			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,656	7,656		7,656	4,918	12,574			35
36	Other (specify):*											36
37	TOTAL Ownership			317,140	317,140	204	317,344	148,959	466,303			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			316,449	316,449		316,449		316,449			42
43	Other (specify):*			1,120	1,120		1,120	(1,120)				43
44	TOTAL Special Cost Centers			317,569	317,569		317,569	(1,120)	316,449			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,945,864	445,070	2,170,690	5,561,624	(0)	5,561,624	(5,112)	5,556,512			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,658)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	101,700	30		9
10	Interest and Other Investment Income	(8,291)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(491)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,521)	20		28
29	Other-Attach Schedule	(18,127)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 66,612		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(71,724)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (71,724)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,112)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

All American Nursing Home

ID# 0026294

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expense	$ (1,120)	43	1
2	Building Co. - Accounting Fees	(1,425)	19	2
3	Building Co. - ILL. RT	(7,611)	21	3
4	PAC Dues	(7,033)	20	4
5	Non Allowable Legal Fees	(938)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,127)		49

All American Nursing Home

ID# 0026294

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number All American Nursing Home **#** 0026294 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				12,328								12,328	1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,658)		1,264									(3,394)	5
6	Maintenance			3,726	4,613								8,339	6
7	Other (specify):*				1,538								1,538	7
8	**TOTAL General Services**	(4,658)		4,990	18,479								18,811	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(365,866)	71,233								(294,633)	17
18	Directors Fees													18
19	Professional Services	(2,363)	1,425	4,068		704							3,834	19
20	Fees, Subscriptions & Promotions	(11,045)											(11,045)	20
21	Clerical & General Office Expenses	(7,611)	7,611	73,010									73,010	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			141									141	24
25	Other Admin. Staff Transportation			4,375									4,375	25
26	Insurance-Prop.Liab.Malpractice			1,992		445							2,437	26
27	Other (specify):*			45,456	4,663								50,119	27
28	**TOTAL General Administration**	(21,019)	9,036	(236,824)	75,896	1,149							(171,762)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,677)	9,036	(231,834)	94,375	1,149							(152,951)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number All American Nursing Home # 0026294 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	101,700	40,513	282		2,132							144,627	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,291)		6		1,391							(6,894)	32
33	Real Estate Taxes					6,308							6,308	33
34	Rent-Facility & Grounds			12,842		(12,842)								34
35	Rent-Equipment & Vehicles			4,918									4,918	35
36	Other (specify):*													36
37	**TOTAL Ownership**	93,409	40,513	18,048		(3,011)							148,959	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,120)											(1,120)	43
44	**TOTAL Special Cost Centers**	(1,120)											(1,120)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	66,612	49,549	(213,786)	94,375	(1,862)							(5,112)	45

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Zikainim Building Partnership	100.00%	$ 40,513	$ 40,513	1
2	V	19	Accounting Fees		Zikainim Building Partnership	100.00%	1,425	1,425	2
3	V	21	ILL RT		Zikainim Building Partnership	100.00%	7,611	7,611	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 49,549	$ * 49,549	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 1,264	$ 1,264	15
16	V	6	REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.	100.00%	3,726	3,726	16
17	V	17	ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.	100.00%	27,234	27,234	17
18	V	19	PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.	100.00%	4,068	4,068	18
19	V	21	CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.	100.00%	63,203	63,203	19
20	V	21	CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.	100.00%	9,807	9,807	20
21	V	24	SEMINARS		STAYCARE MANAGEMENT, LTD.	100.00%	141	141	21
22	V	25	ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.	100.00%	4,375	4,375	22
23	V	26	INSURANCE		STAYCARE MANAGEMENT, LTD.	100.00%	1,992	1,992	23
24	V	27	EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.	100.00%	45,456	45,456	24
25	V	30	DEPRECIATION		STAYCARE MANAGEMENT, LTD.	100.00%	282	282	25
26	V	32	INTEREST		STAYCARE MANAGEMENT, LTD.	100.00%	6	6	26
27	V	34	BUILDING RENT		STAYCARE MANAGEMENT, LTD.	100.00%	12,842	12,842	27
28	V	35	EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.	100.00%	4,918	4,918	28
29	V								29
30	V	17	MANAGEMENT FEES	393,100	STAYCARE MANAGEMENT, LTD.	100.00%		(393,100)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 393,100			$ 179,314	$ * (213,786)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 3,106	$ 3,106	15
16	V	1	DIET. COMP - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	9,222	9,222	16
17	V	6	MAINT. COMP.		STAY CARE MANAGEMENT, LTD.	100.00%	4,613	4,613	17
18	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	285	285	18
19	V	7	EMP. BEN. - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	776	776	19
20	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	477	477	20
21	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	56,979	56,979	21
22	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	14,254	14,254	22
23	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	3,770	3,770	23
24	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	893	893	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 94,375	$ * 94,375	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	576	$ 576	15
16	V	26	INSURANCE		DOUBLE YOU REALTY, LLC	100.00%	445	445	16
17	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC	100.00%	2,132	2,132	17
18	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC	100.00%	1,391	1,391	18
19	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	128	128	19
20	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC	100.00%	6,308	6,308	20
21	V								21
22	V	34	BUILDING RENT	12,842	DOUBLE YOU REALTY, LLC	100.00%		(12,842)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,842			$ 10,980	$ * (1,862)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JEFFREY WEBSTER	50.00%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	ZIKAINIM PARTNERSHIP	LINCOLNWOOD	BUILDING CO.	1
2	HOWARD WENGROW	50.00%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3			ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEEI	3
4			HICKORY NURSING PAVILION, INC.	HICKORY HILLS				4
5			RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5	7.14%	Alloc. Salary	$ 14,254	17-07	1
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	20	30.77%	Alloc. Salary	56,979	17-07	2
3	Sara Webster	Relative	Dietary		See Attached	1.54	30.74%	Alloc. Salary	3,106	01-07	3
4	Deborah Wengrow	Relative	Dietary		See Attached	1.54	30.74%	Alloc. Salary	9,222	01-07	4
5	Ephraim Braunstein	Relative	Clerical		See Attached	6.96	17.40%	Alloc. Salary	14,894	21-07	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 98,455		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	208,514	6	$ 7,261	$	36,284	$ 1,264	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	208,514	6	21,410		36,284	3,726	2
3	17	ADMIN. SALARY	PATIENT DAYS	208,514	6	156,508	156,508	36,284	27,234	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	23,378		36,284	4,068	4
5	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	208,514	6	363,209	363,209	36,284	63,203	5
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	208,514	6	56,356		36,284	9,807	6
7	24	SEMINARS	PATIENT DAYS	208,514	6	810		36,284	141	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	208,514	6	25,144		36,284	4,375	8
9	26	INSURANCE	PATIENT DAYS	208,514	6	11,450		36,284	1,992	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	208,514	6	261,220		36,284	45,456	10
11	30	DEPRECIATION	PATIENT DAYS	208,514	6	1,621		36,284	282	11
12	32	INTEREST	PATIENT DAYS	208,514	6	34		36,284	6	12
13	34	BUILDING RENT	PATIENT DAYS	208,514	6	73,800		36,284	12,842	13
14	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	208,514	6	28,262		36,284	4,918	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,030,464	$ 519,717		$ 179,314	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	1.54	3,106	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	1.54	9,222	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	6.96	4,613	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	928		1.54	285	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,524		1.54	776	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,741		6.96	477	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	185,182	185,182	20.00	56,979	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,550	199,550	5.00	14,254	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,252		20.00	3,770	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,502		5.00	893	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 482,293	$ 451,346		$ 94,375	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DOUBLE YOU REALTY, LLC
Street Address: 3737 W. ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	3,310		36,284	576	1
2	26	INSURANCE	PATIENT DAYS	208,514	6	2,559		36,284	445	2
3	30	DEPRECIATION	PATIENT DAYS	208,514	6	12,254		36,284	2,132	3
4	32	INTEREST EXPENSE	PATIENT DAYS	208,514	6	7,994		36,284	1,391	4
5	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	208,514	6	735		36,284	128	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	208,514	6	36,251		36,284	6,308	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 63,103	$		$ 10,980	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line Of Credit				1,653,924			63,135	6
7	Partners Loan Payable		X					200,000				7
8												8
9	TOTAL Facility Related						$	$ 1,853,924			$ 63,135	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,291)	10
11	Allocated from Staycare	X									6	11
12	Allocated from Double You	X									1,391	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,894)	14
15	TOTALS (line 9+line14)						$	$ 1,853,924			$ 56,241	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number All American Nursing Home # 0026294 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	177,563	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	194,238	2
3. Under or (over) accrual (line 2 minus line 1).	$	16,675	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	90,202	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	204	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 611 **For** 05, 13 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	107,081	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	164,108	8
	2013	166,661	9
	2014	169,219	10
	2015	172,392	11
	2016	187,930	12

Due to prepayments of $103,365, Line 7 (above) and Page 4, Line 33 do not match.
2017 Accrual = $187,930 x 1.03 - Prepayments = $90,202
Allocated from Double You Realty: $6,308

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME All American Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026294

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-113-017-0000	Long Term Care Property	$ 158,611.07	$ 158,611.07
2.	14-08-113-018-0000	Long Term Care Property	$ 12,415.26	$ 12,415.26
3.	14-08-113-019-0000	Long Term Care Property	$ 8,588.54	$ 8,588.54
4.	14-08-113-020-0000	Long Term Care Property	$ 8,314.79	$ 8,314.79
5.	10-35-329-014-0000	Home Office	$ 23,388.05	$ 4,069.81
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 211,317.71	$ 191,999.47

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME All American Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026294

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,350 B. General Construction Type: Exterior Brick Frame Fireproof Brick Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	18,750	1981	$ 87,895	1
2	Allocated from Double You Realty			8,701	2
3	TOTALS	18,750		$ 96,596	3

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144			1969	$ 514,131	$		$	$	$ 514,131	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1968	2,650		20			2,650	9
10	Various			1972	5,248		20			5,248	10
11	Various			1974	6,075		20			6,075	11
12	Various			1975	22,572		20			22,572	12
13	Various			1978	24,379		20			24,379	13
14	Various			1979	217,961		20			217,961	14
15	Various			1980	41,050		20			41,050	15
16	Various			1981	9,192		20			9,192	16
17	Various			1985	30,550		20			30,550	17
18	Various			1986	49,476		20			41,484	18
19	Various			1987	32,346		20	95	95	20,831	19
20	Various			1988	11,000		20			6,838	20
21	Various			1989	60,399		20			52,707	21
22	Various			1990	10,050		20			9,085	22
23	Various			1991	38,074		20			33,567	23
24	Various			1992	22,062		20			20,555	24
25	Various			1993	15,250		20			14,650	25
26	Various			1994	42,293		20			40,855	26
27	Various			1995	185,841		20			183,532	27
28	Various			1996	60,561		20			58,572	28
29	Various			1997	37,873		20	797	797	37,868	29
30	Various			1998	20,369		20	1,021	1,021	20,042	30
31	Various			1999	27,926		20	1,397	1,397	25,837	31
32	Various			2000	17,615		20	882	882	15,387	32
33	Various			2001	22,954		20	847	847	20,143	33
34	Various			2002	20,041		20			20,041	34
35	Various			2003	3,863		20	193	193	2,799	35
36	Various			2004	15,301		20	765	765	10,370	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2005	$ 25,109	$	20	$ 490	$ 490	$ 21,475	37
38	Various	2006	36,422		20	996	996	28,180	38
39	Various	2007	105,233		20	6,048	6,048	78,984	39
40	Various	2008	51,323		20	4,862	4,862	46,361	40
41	Various	2009	130,247		20	12,885	12,885	111,501	41
42	Various	2010	24,165		20	1,560	1,560	14,702	42
43	Various	2011	6,379		20			6,379	43
44	Various	2012	13,928		20	1,405	1,405	8,488	44
45	Various	2013	68,744		20	6,393	6,393	28,955	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,842,762	40,513		92,138	51,625	92,138	67
68	Related Party Allocations (Pages 12H & 12I)		91,542	2,132		2,551	419	35,081	68
69	Financial Statement Depreciation			42,415			(42,415)		69
70	TOTAL (lines 4 thru 69)		$ 3,962,956	$ 85,060		$ 135,325	$ 50,265	$ 1,981,215	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,962,956	$ 85,060		$ 135,325	$ 50,265	$ 1,981,215	1
2	Cylinder	2014	11,722		20	586	586	2,198	2
3	Replace Elevator Hydraulic Cylinder	2014	24,500		20	1,225	1,225	4,390	3
4	Passenger 1 Elevator Hydraulic Cylinder Repair	2014	4,089		20	204	204	784	4
5	Lobby & Corridorsremove & Install Wallcovering	2014	17,397		20	870	870	3,334	5
6	Doors, Unicombo Closer Reinforcement, Power Adjust Aluminum	2014	2,722		20	136	136	510	6
7	Install Fire Pump Annunciator	2014	2,679		20	134	134	491	7
8	Repair & Replace Burner Controls For Steam Boilers	2014	4,357		20	218	218	781	8
9	Replace Pipe In Crawlspace, Trench Tunnel & Replace Drain	2014	19,700		20	985	985	3,530	9
10	Piping Replace 5 Risers	2014	4,200		20	210	210	735	10
11	Piping Run 5 Risers, 1Inch Copper Lines, 2 Inch Return Line	2014	6,000		20	300	300	1,000	11
12	Furnish & Install Pump For Steam Boilers	2014	6,900		20	345	345	1,093	12
13	Piping East Side / North Side Of Building	2014	25,100		20	1,255	1,255	3,870	13
14	Open Wall & Install Piping	2014	4,250		20	213	213	655	14
15	Install Sprinkler Heads South Stairwell, Bathroom & 2Nd Floor L	2015	6,350		20	318	318	926	15
16	New Elevator Submercible Pump & Motor	2015	6,752		20	338	338	928	16
17	Movfr Door Operator	2015	5,528		20	276	276	668	17
18	Door Screen And Operator Board	2015	3,182		20	159	159	345	18
19	Heat Work	2015	7,832		20	392	392	1,175	19
20	Replace Drain Pipe	2015	6,200		20	310	310	646	20
21	Floor In Rear Corridor	2015	6,093		20	305	305	660	21
22	Install New Traps & Cut Pipes In Tunnel	2015	3,300		20	165	165	495	22
23	2Nd Floor East A/C Unit Install	2015	8,160		20	408	408	1,054	23
24	Elevator Motor	2016	5,450		20	273	273	431	24
25	Elevator Car Sill	2016	3,300		20	165	165	248	25
26	Bumper Guards & End Caps	2016	7,370		20	369	369	614	26
27	Furnish & Install Back Double Doors	2016	3,850		20	193	193	305	27
28	Freezer Compressor	2017	2,583		20	301	301	301	28
29	Water Heater	2017	8,993		20	62	62	62	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,515	$ 85,060		$ 146,040	$ 60,980	$ 2,013,444	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	East Elevation Canopy Erection, Demolition, Steel Work -	2017	1,324,940		20	66,247	66,247	66,247	9
10	-Window Replacements, Concrete Removal/Infill & Strip -	2017			20				10
11	- Frontage, Steelwork, Rebuild South Elevation	2017			20				11
12	Drawings & Rendition For Exterior Frame	2017	24,322		20	1,216	1,216	1,216	12
13	- Structural Report/Drawings/Detail/Permits	2017			20				13
14	Furnish/Install 18 Temp Heaters, Lobby Insulation -	2017	208,260		20	10,413	10,413	10,413	14
15	-Baseboard Heater/Gas Line Install/ Scaffolding Tarp -	2017			20				15
16	-Patio Installation, Roofing, Roof Silver Coating	2017			20				16
17	Piping In Dining Area	2017	12,200		20	610	610	610	17
18	Econocare - Handrail, end caps, corner guards	2017	10,605		20	530	530	530	18
19	Open masonry walls to expose damage sewer pipes	2017	28,856		20	1,443	1,443	1,443	19
20	Pipes in 18 rooms.	2017	39,305		20	1,965	1,965	1,965	20
21	Upgrade electrical service to 1600 amp	2017	7,295		20	365	365	365	21
22	Relocate exiting pump, repair pump, install new booster pump	2017	12,000		20	600	600	600	22
23	for new 18 rooms (2-4 fl) and rest of bldg	2017			20				23
24	Electrical - install conduit and junction boxes for	2017	9,000		20	450	450	450	24
25	emergency call & nurse call in 18 rms	2017			20				25
26	Install 2 wood lintels & frame support for front entrance	2017	2,650		20	133	133	133	26
27	Steel piping in 18 rooms, lobby, 1st fl corridor	2017	120,300		20	6,015	6,015	6,015	27
28	Roofing - shorting of 18 sprinkler pipes	2017	6,380		20	319	319	319	28
29	Rising Development - Install 39 cable boxes in 18 rms,	2017	7,339		20	367	367	367	29
30	Roof Permit	2017	525		20	26	26	26	30
31	Tee Jay - Sliding door	2017	6,505		20	325	325	325	31
32	Replacement of 3rd Fl AC System	2017	8,420		20	421	421	421	32
33	36 Exit Signs	2017	13,860		20	693	693	693	33
34	TOTAL (lines 1 thru 33)		$ 1,842,762	$		$ 92,138	$ 92,138	$ 92,138	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,842,762	$		$ 92,138	$	$ 92,138	1
2									2
3	Current Book Depreciation			40,513			(40,513)		3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,842,762	$ 40,513		$ 92,138	$ (40,513)	$ 92,138	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	83,166	2,132	35	2,132		31,900	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	3,852		20	193	193	2,804	9
10	Allocated from Staycare Management	2016	4,524		20	226	226	377	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 91,542	$ 2,132		$ 2,551	$ 419	$ 35,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 91,542	$ 2,132		$ 2,551	$ 419	$ 35,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 91,542	$ 2,132		$ 2,551	$ 419	$ 35,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 688,000	$	$ 40,285	$ 40,285	10	$ 590,961	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	9,874				10	9,874	73
74								74
75	TOTALS	$ 697,874	$	$ 40,285	$ 40,285		$ 600,835	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Staycare Manage	2017	$ 5,889	$ 282	$ 717	$ 435	5	$ 4,544	76
77										77
78										78
79										79
80	TOTALS			$ 5,889	$ 282	$ 717	$ 435		$ 4,544	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,981,874	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,342	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 187,042	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 101,700	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,618,823	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	18 Rms- Walls, Tiles, Curtains	$ 400,319	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,918 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2014 Lexus RX350	$ 638	$ 7,656	17
18					18
19					19
20					20
21	TOTAL		$ 638	$ 7,656	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number All American Nursing Home # 0026294 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 113,002	$ 127,024	1
2	Cash-Patient Deposits	25,886	25,886	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	570,684	570,684	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	264,289	264,289	6
7	Other Prepaid Expenses	2,651	2,651	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	2,043	2,043	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 978,555	$ 992,577	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		138,750	13
14	Buildings, at Historical Cost		1,913,250	14
15	Leasehold Improvements, at Historical Cost	1,077,336	2,854,205	15
16	Equipment, at Historical Cost	635,630	635,630	16
17	Accumulated Depreciation (book methods)	(1,432,626)	(3,386,389)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,718,552	400,321	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,998,892	$ 2,555,767	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,977,447	$ 3,548,344	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 382,760	$ 382,760	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,886	25,886	28
29	Short-Term Notes Payable	1,653,924	1,853,924	29
30	Accrued Salaries Payable	269,526	269,526	30
31	Accrued Taxes Payable (excluding real estate taxes)	556	556	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,202	90,202	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	178	178	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,423,032	$ 2,623,032	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,423,032	$ 2,623,032	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 554,415	$ 925,312	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,977,447	$ 3,548,344	48

***(See instructions.)**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,205,207	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,205,209	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(650,794)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (650,794)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 554,415	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,902,312	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,902,312	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,291	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,291	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	227	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 227	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,910,830	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,478,592	31
32	Health Care	2,011,536	32
33	General Administration	1,436,787	33
	B. Capital Expense		
34	Ownership	317,140	34
	C. Ancillary Expense		
35	Special Cost Centers	1,120	35
36	Provider Participation Fee	316,449	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,561,624	40
41	**Income before Income Taxes (line 30 minus line 40)****	(650,794)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (650,794)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,902,312	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,902,312	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,825	3,243	$ 120,479	$ 37.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,247	3,341	96,423	28.86	3
4	Licensed Practical Nurses	19,399	21,636	566,589	26.19	4
5	CNAs & Orderlies	50,290	56,283	686,823	12.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,020	2,322	29,432	12.68	8
9	Activity Director	1,872	2,112	36,608	17.33	9
10	Activity Assistants	3,399	3,744	38,898	10.39	10
11	Social Service Workers	6,925	7,623	134,759	17.68	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,160	41,474	19.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,235	24,777	286,025	11.54	15
16	Dishwashers					16
17	Maintenance Workers	18,189	19,630	260,195	13.25	17
18	Housekeepers	20,379	22,453	273,899	12.20	18
19	Laundry	1,978	2,266	26,885	11.86	19
20	Administrator	1,916	2,080	90,680	43.60	20
21	Assistant Administrator	1,784	2,080	35,100	16.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,058	2,230	41,982	18.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,982	2,245	35,257	15.70	31
32	Other Health Care(specify)					32
33	Other(specify)	3,877	4,461	144,356	32.36	33
34	TOTAL (lines 1 - 33)	166,359	184,686	$ 2,945,864 *	$ 15.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,784	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,628	10-03	39
40	Physical Therapy Consultant	Monthly	33,351	10a-03	40
41	Occupational Therapy Consultant	Monthly	21,020	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	183	10a-03	43
44	Activity Consultant	33	1,692	11-03	44
45	Social Service Consultant	18	976	12-03	45
46	Other(specify)				46
47	Religious Services	Monthly	2,500	12-03	47
48					48
49	TOTAL (lines 35 - 48)	51	$ 93,134		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Claussen	Administrator	0	$ 90,680
Ari Lebowicz	Asst. Admin	0	35,100
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,780

B. Administrative - Other

Description	Amount
Staycare - Management Fees	$ 393,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 393,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 23,372
Personnel Planners	Unemployment Consultant	990
See Attached	Legal Fees	18,297
Staycare Management	Reimbursement Consultant	28,764
KBC Computer Services, Ltd.	Computer Service	4,005
Sarnoff & Baccash	RE Tax Appeal	76
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 75,504

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,713
Unemployment Compensation Insurance	19,641
FICA Taxes	217,778
Employee Health Insurance	178,879
Employee Meals	8,161
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	302
401K	3,359
Union Pension Expense	27,910
Christmas Expense	2,360
TOTAL (agree to Schedule V, line 22, col.8)	$ 516,103

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,033
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 405)	4,050
Patient Background Checks	
Dues & Subscriptions	14,279
Licenses/Permits & Fees	5,793
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,155

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,086
Allocated from Staycare	141
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,227

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $21,312**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,426** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **316,449**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,161** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees